



AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ **DOB:** _____

Health Center/School/Organization _____

Phone _____ Fax _____

I authorize the exchange of information to and/or from **True Joy Counseling and Consulting, PLLC** (select Provider)

Type of Information to Release/Disclose:

- All Records Medical/Hospital Records Treatment Plans Diagnosis Mental Health Summary
- Psychotherapy Notes *(by checking this box I am waiving any psychotherapist-patient privilege)*
- Psychological/Medical Testing Course of Treatment Other: _____

The Purpose of Release/Disclosure:

- Ongoing Treatment Coordination of Care Family/Support System Integration Consultation
- Legal Evaluation Health Benefit Utilization Transfer Other: _____

Specific Exceptions _____

This consent remains in effect until _____. I understand that I may revoke this authorization, in writing at any time, unless action based on it has already taken place.

The designated information about me may be transmitted by fax, other electronic file transfer mechanisms, or discussed by telephone by the authorized individual and/or practice designated above. I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed psychotherapists, except as provided in Florida Statutes Section 491.0147 and in certain legal exceptions. In general, these exceptions pertain to matters of danger to self and others, or to prevent the potential abuse or neglect of vulnerable populations. I further understand that the potential exists for disclosure in proceedings or actions by other parties subsequent to the information release authorize and may not be protected under the HIPAA regulations.

This is to certify that I have given consent freely and voluntarily, and the benefits and disadvantages of releasing the information are known to me.

Signature _____ **Print Name** _____ **Date** _____
(Patient, Parent, Guardian, or Personal Representative)

*****IF THIS FORM IS NOT SIGNED AND SUBMITTED IN PERSON TO TRUE JOY COUNSELING AND CONSULTING, IT MUST BE NOTARIZED*****

State of _____ County of _____. This authorization was acknowledged before me on this _____ day of _____, 20_____.

Signature of Notary Public _____

Notary Printed Name _____

(Notary Seal)